PHYSICIAN ASSISTANT
APPLICATION FOR REINSTATEMENT
FOR THE BIENNIAL REGISTRATION PERIOD 2007 - 2009
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

(For Board Use Only)

License No._____

File No._____

I hereby apply for renewal of biennial registration and enclose the appropriate fee as indicated below:

_____PHYSICIAN ASSISTANT REINSTATEMENT FEE: $800.00

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office.

_____ _____
Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT P.A. LICENSE EXPIRES ON JUNE 30, 2007. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2007 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Registration renewal requires the submission of proof of current certification by the National Commission on Certification of Physician Assistants. Be advised, you must submit your CME's following the July 1, 2007 renewal.

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

E-mail address_____

3. List name(s) of your supervising physician(s) with their addresses and phone numbers for EACH and EVERY practice location:

Supervising Physician Name: Address(es) of Practice Location(s): Phone Number(s):

_____

_____

(If more space is needed, attach a separate sheet.)

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

Code **Code**

Primary Scope of Practice _____ **Secondary Scope of Practice** _____

All of the following questions refer to the time period July 1, 2005, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice as a physician assistant" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety? _____Yes _____No

2. If you have a medical condition which in any way impairs or limits your ability to practice as a physician assistant, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____ No _____N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? _____Yes _____ No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____ No _____N/A

5. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself (including any military tort claims if applicable)? _____Yes _____No

6. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal or expungement.

_____Yes _____No

7. Have you been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory? _____Yes _____No

8. Have you had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory? _____Yes _____No

10. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? _____Yes _____No

11. Have you been: a) asked to respond to an investigation, b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician assistant by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _____Yes _____No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No

13. Is your license <u>currently</u> contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? _____Yes _____No

14. Are you a foreign physician assistant, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? _____Yes _____No

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action.

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

I completed a minimum of 40 hours of continuing medical education (CME) as defined by the American Academy of Physician Assistants, during the period July 1, 2005 through June 30, 2007.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **YOUR COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME) COMPLETION WILL NOT BE RETURNED TO YOU.**

Please place a check mark next to one of the following statements:

_____ (a) I completed a minimum of 40 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2005 through June 30, 2007;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2006 through June 30, 2006, the second six months of the past biennial period, and completed a minimum of 30 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2006 through December 31, 2006, the third six months of the past biennial period, and completed a minimum of 20 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2007 through June 30, 2007, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty;

CERTIFICATION STATEMENT

I am currently certified by the National Commission on Certification of Physician Assistants.

- **ATTACH COPY OF PROOF OF YOUR CURRENT CERTIFICATION.**
- **YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL NOT BE RETURNED TO YOU.**

HOME ADDRESS & PHONE NUMBER ***(REQUIRED)***

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

BY SIGNING ON THE SIGNATURE LINE BELOW:

I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I UNDERSTAND HAVE ANSWERED THE QUESTIONS TRUE TO THE BEST OF MY KNOWLEDGE. **_____Yes _____No**

I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND

I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) THE APPROPRIATE PROOF OF CURRENT CERTIFICATION BY THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS; (c) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (d) WRITTEN EXPLANATION (S) TO ANY "YES" ANSWER(S).

_____ _____

Date **Signature (SIGNATURE STAMP UNACCEPTABLE)**